

10007

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Teroy Eugene</u> First Middle Last		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>R</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/9/12</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>John M. Berry</u>	
14. MOTHER'S MAIDEN NAME <u>Amanda Jamison</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>146-18960</u>		17. INFORMANT <u>Halligan Berry</u> Address <u>Lusby, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Chest by a tractor</u> <u>9/12.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Which fell backwards over</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Was falling asleep in seat when he fouled</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>to Chain beam</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> o. m. <u>17</u> 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Home</u>
20f. (City or town) <u>Lusby Calvert</u>		(County) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Wand</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-20-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) <u>Lusby,</u>	
(State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Frederick</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASES PREEXISTING	
SIGNATURE OF EXAMINER		DATE		PLACE	

Witnessed by  
J. Edgar Hoover

John Doe

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASES PREEXISTING	
SIGNATURE OF EXAMINER		DATE		PLACE	

1-2-34  
John Doe  
1-2-34

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10000

Reg. Dist. No.

10008

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lusby</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookmont</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>4109 Maryland <del>Ave</del> Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>BLAIR</b> Last <b>BRITTON</b>		4. DATE OF DEATH Month <b>September</b> Day <b>28</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1919</b>
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Army Map Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>	11. BIRTHPLACE (State or foreign country) <b>N. C.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Robert Hall Britton</b>		14. MOTHER'S MAIDEN NAME <b>Alma Henderson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Pauline Britton - 4109 Maryland Dr.</b>		Address <b>Brookmont, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>850X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Boat capsized in bay</b>	
20c. TIME OF INJURY Month, Day, Year <b>4</b> Hour <b>3:00</b> p. m. <b>9/27</b> 19 <b>58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>water</b>	20f. (City or town) (County) (State) <b>Lusby Clavert Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William V. Lovitt, Jr., M.D.</b>		DATE SIGNED <b>9/29/58</b>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/2/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckner &amp; Sons - Balt. Md</b>		24a. REC'D BY REGISTRAR <b>SEP 30 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF CAUSE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		10/15/1960		Home	
Residence		Occupation		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner	
123 Main St.		Teacher		Heart Disease		Natural		[Signature]		[Signature]	
City		State		County		District		Date		Time	
Baltimore		Maryland		Baltimore		15th		10/15/1960		10:00 AM	
Medical History		Previous Illnesses		Injury or Poison		Alcohol or Drugs		Autopsy		Remarks	
None		Hypertension		None		None		No		None	
Family History		Social History		Smoking		Drinking		Heredity		Other	
None		None		Yes		No		None		None	
Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner		Date		Time	
Heart Disease		Natural		[Signature]		[Signature]		10/15/1960		10:00 AM	

## Reg. Dist. No.

VS AIS (4)  
15M 9/55

CERTIFICATE OF DEATH

10009

*[Faint, mostly illegible handwritten text and stamps are visible throughout the form, including names like "John" and "Mary", and dates like "1910".]*

**DECEASED** *[Name]* **DATE OF DEATH** *[Date]*

**PLACE OF DEATH** *[Location]*

**CAUSE OF DEATH** *[Cause]*

**DIAGNOSIS** *[Diagnosis]*

**AGE** *[Age]* **SEX** *[Sex]* **RACE** *[Race]*

**BIRTH DATE** *[Date]* **BIRTH PLACE** *[Place]*

**EDUCATION** *[Education]* **OCCUPATION** *[Occupation]*

**RELIGION** *[Religion]* **MARRIAGE** *[Marriage]*

**PREVIOUS ILLNESS** *[Previous Illness]* **PREVIOUS SURGERY** *[Previous Surgery]*

**PREVIOUS TRAUMA** *[Previous Trauma]* **PREVIOUS ACCIDENT** *[Previous Accident]*

**PREVIOUS DRUGS** *[Previous Drugs]* **PREVIOUS ALCOHOL** *[Previous Alcohol]*

**PREVIOUS TOBACCO** *[Previous Tobacco]* **PREVIOUS OTHER** *[Previous Other]*

**PREVIOUS MEDICATION** *[Previous Medication]* **PREVIOUS TREATMENT** *[Previous Treatment]*

**PREVIOUS HOSPITALIZATION** *[Previous Hospitalization]* **PREVIOUS PHYSICIAN** *[Previous Physician]*

**PREVIOUS SURGEON** *[Previous Surgeon]* **PREVIOUS NURSE** *[Previous Nurse]*

**PREVIOUS ATTENDING PHYSICIAN** *[Previous Attending Physician]* **PREVIOUS ASSISTANT PHYSICIAN** *[Previous Assistant Physician]*

**PREVIOUS NURSE** *[Previous Nurse]* **PREVIOUS ATTENDING NURSE** *[Previous Attending Nurse]*

**PREVIOUS ASSISTANT NURSE** *[Previous Assistant Nurse]* **PREVIOUS OTHER** *[Previous Other]*

**PREVIOUS MEDICAL RECORD** *[Previous Medical Record]* **PREVIOUS SURGICAL RECORD** *[Previous Surgical Record]*

**PREVIOUS PATHOLOGICAL RECORD** *[Previous Pathological Record]* **PREVIOUS RADIOLOGICAL RECORD** *[Previous Radiological Record]*

**PREVIOUS LABORATORY RECORD** *[Previous Laboratory Record]* **PREVIOUS OTHER** *[Previous Other]*

**PREVIOUS MEDICAL HISTORY** *[Previous Medical History]* **PREVIOUS SURGICAL HISTORY** *[Previous Surgical History]*

**PREVIOUS PATHOLOGICAL HISTORY** *[Previous Pathological History]* **PREVIOUS RADIOLOGICAL HISTORY** *[Previous Radiological History]*

**PREVIOUS LABORATORY HISTORY** *[Previous Laboratory History]* **PREVIOUS OTHER** *[Previous Other]*

**PREVIOUS MEDICAL TREATMENT** *[Previous Medical Treatment]* **PREVIOUS SURGICAL TREATMENT** *[Previous Surgical Treatment]*

**PREVIOUS PATHOLOGICAL TREATMENT** *[Previous Pathological Treatment]* **PREVIOUS RADIOLOGICAL TREATMENT** *[Previous Radiological Treatment]*

**PREVIOUS LABORATORY TREATMENT** *[Previous Laboratory Treatment]* **PREVIOUS OTHER** *[Previous Other]*

**PREVIOUS MEDICAL RECORD** *[Previous Medical Record]* **PREVIOUS SURGICAL RECORD** *[Previous Surgical Record]*

**PREVIOUS PATHOLOGICAL RECORD** *[Previous Pathological Record]* **PREVIOUS RADIOLOGICAL RECORD** *[Previous Radiological Record]*

**PREVIOUS LABORATORY RECORD** *[Previous Laboratory Record]* **PREVIOUS OTHER** *[Previous Other]*

**PREVIOUS MEDICAL HISTORY** *[Previous Medical History]* **PREVIOUS SURGICAL HISTORY** *[Previous Surgical History]*

**PREVIOUS PATHOLOGICAL HISTORY** *[Previous Pathological History]* **PREVIOUS RADIOLOGICAL HISTORY** *[Previous Radiological History]*

**PREVIOUS LABORATORY HISTORY** *[Previous Laboratory History]* **PREVIOUS OTHER** *[Previous Other]*

**PREVIOUS MEDICAL TREATMENT** *[Previous Medical Treatment]* **PREVIOUS SURGICAL TREATMENT** *[Previous Surgical Treatment]*

**PREVIOUS PATHOLOGICAL TREATMENT** *[Previous Pathological Treatment]* **PREVIOUS RADIOLOGICAL TREATMENT *[Previous Radiological Treatment]***

**PREVIOUS LABORATORY TREATMENT** *[Previous Laboratory Treatment]* **PREVIOUS OTHER** *[Previous Other]*

*[Vertical text on the right margin, mostly illegible.]*

10010

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dowell</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Etta Curtis</b>		4. DATE OF DEATH <b>Sept. 6 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/12/84</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Roman Watts</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Briscoe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Walter Curtis, Dowell, Md.</b>	
17. INFORMANT <b>Walter Curtis, Dowell, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>450.0</b> DUE TO <b>Chronic renal-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic renal-sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1</b> , 19 <b>58</b> , to <b>Sept 6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept 6</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Roberto de Villarreal</b>		DATE SIGNED <b>Sept 6/58</b>	
PHYSICIAN'S NAME (Type) <b>Roberto de Villarreal</b>		St. Leonard, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>a-c-58</b>	22b. DATE THEREOF <b>9-8-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Eastern Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Calvert, Co Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. E. Sewell</b>		24a. REC'D BY REGISTRAR <b>SEP 15 '58</b>	
ADDRESS <b>Prince Fred, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10011

CERTIFICATE OF DEATH

10003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabrest</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Cabrest</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broomes Island</u>	
c. LENGTH OF STAY IN 1b <u>7 mo.</u>		d. STREET ADDRESS <u></u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabrest County Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>G. Frank Elliott</u>		4. DATE OF DEATH Month Day Year <u>Sept. 26, 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 23, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. Franklin Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth O'Dunn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Etta Buckmaster - Cherry, Md</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350x Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pericarditis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>1958</u> , that I last saw the deceased alive on <u>Feb 1 - 1958</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page Jett</u> M.D. <u>Prince Frederick, MD.</u>		DATE SIGNED <u>9-26-58</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 28, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broomes Island Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Broomes Island - Cabrest Co - Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness &amp; Son - Mutual, Md.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>SEP 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10004

## 10012 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CALVERT Co.</u> MARYLAND		STATE <u>Md</u> COUNTY <u>Calvert Co.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> 2 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNKIRK</u>	
TOWN <u>Prince Frederick</u>		LENGTH OF STAY (in this place)		TOWN <u>DUNKIRK</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CALVERT Nursing Home</u>		1					
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Matthe ELLEN Griffith</u>				<u>Sept 12 19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 25</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>DUNKIRK</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>EDWIN WARD</u>				14. MOTHER'S MAIDEN NAME <u>MARY WARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yas, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>W.F. WARD JR. DUNKIRK Md</u>			
(If Yes, give war or dates of service)							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3 June</u> , 19 <u>56</u> , to <u>12 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 Sept</u> , 19 <u>58</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Huntingtown Md</u>		DATE SIGNED <u>12 Sept 58</u>	
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Sept 18/58</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		LOCATION (City, town, or county) (State) <u>Friendship Md</u>	
24. REC'D BY REGISTRAR <u>SEP 16 '58</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

# CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEAREST RELATIVE

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF JUDGE

23. SIGNATURE OF DISTRICT ATTORNEY

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF CLERK

26. SIGNATURE OF RECORDER

27. SIGNATURE OF INDEXER

28. SIGNATURE OF FILE CLERK

29. SIGNATURE OF ASSISTANT CLERK

30. SIGNATURE OF CHIEF CLERK

31. SIGNATURE OF DEPUTY CHIEF CLERK

32. SIGNATURE OF RECORDS SECTION

33. SIGNATURE OF STATISTICS SECTION

34. SIGNATURE OF LABORATORY SECTION

35. SIGNATURE OF RADIOLOGY SECTION

36. SIGNATURE OF PATHOLOGY SECTION

37. SIGNATURE OF ANATOMY SECTION

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251. SIGNATURE OF

10013

## CERTIFICATE OF DEATH

10005

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Calvert</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>X Owings</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Valerie Casandra Jones</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>13</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1958</b>
9. AGE (In years last birthday) yrs. <b>1</b> Months <b>15</b> Days <b>15</b> Hours <b></b> Min. <b></b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Calvin Jones</b>		14. MOTHER'S MAIDEN NAME <b>Thelma Morsell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Thelma Morsell, Owings, Md.</b>	
17. INFORMANT <b>Thelma Morsell, Owings, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>772.5</b> <b>Molnutation -</b> DUE TO <b>Dehydration -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Premature (1 month old)</b> DUE TO (c) <b>Premature (1 month old)</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/2</b> , 19 <b>58</b> , to <b>9/13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept 13</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Roberto de Villarreal</b>		ADDRESS (Street, city or town, state) <b>5th Avenue</b>	
PHYSICIAN'S NAME (Type) <b>R DE VILLARREAL</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-14, 58</b>	22b. DATE THEREOF <b>Patuxent</b>	22c. NAME OF CEMETERY OR CREMATORY <b>7 Huntington, Md</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. E. Sewell Prince Frederick</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 17 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10006

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Calvert</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownsville</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Calvert</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownsville</u><br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) First <u>Wallace</u> Middle <u>Jones</u> Last <u>Jones</u>   |  | 4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>1958</u>  |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>E</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>May 16, 83</u> yrs. <u>15</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <u>15</u> yrs. IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u>12</u> Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |   |
| 13. FATHER'S NAME <u>Joseph Jones</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Leopold Jones Marshall</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>219-36-1741</u>  |   |
| 17. INFORMANT <u>Georgia Jones</u>   |  | Address <u>1262 Florida Ave. N.E.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cashier's Poison</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cya</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Died suddenly at home</u> |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month <u>9</u> Day <u>14</u> Year <u>1958</u> Hour <u>9</u> a. m. <u>15</u> p. m.  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Calvert</u>   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .  |  |   |   |
| ACTUAL SIGNATURE <u>H. W. Jones</u>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <u>H. W. Jones</u>  |  | DATE SIGNED <u>9/14/58</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-8-58</u>  | 22b. DATE THEREOF <u>9-8-58</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Moses</u>   | 22d. LOCATION (City, town, or county) (State) <u>aa. Co. Md</u>   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>   |  | ADDRESS <u>Prince Fred, Md</u>  |   |
| 24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-CAMBRIDGE, 1901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Prof. J. A. J. J.

140. 05-110

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10015

## CERTIFICATE OF DEATH

10007

Reg. Dist. No.

|   |                                  |   |   |  |  |   |  |
|---|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>   |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>North Beach</b>                                     |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Calvert County Hospital</b>   |                                  |   |   | d. STREET ADDRESS<br><b>1</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Baby Girl Lephew</b>  |                                  |   |   | 4. DATE OF DEATH <b>Sept. 23 1958</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 21, 1958</b> |  | 9. AGE (In years last birthday) yrs.<br><b>2</b> | IF UNDER 1 YEAR<br>Months <b>2</b>  | IF UNDER 24 HRS.<br>Hours <b>2</b> Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Buddy Edward Lephew</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Patricia Burke</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |   | 17. INFORMANT<br><b>Patricia Lephew, North Beach, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Prematurity (6 months)</b><br><b>776X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>(c) _____ |                                  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Sept 21</b> , 19 <b>58</b> , to <b>Sept</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept 23</b> , 19 <b>58</b> , and that death occurred at <b>10:45</b> M, from the causes and on the date stated above.                                |                                  |   |   |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Roberto de Villarreal</b>  |                                  |   |   | ADDRESS (Street, city or town, state)<br><b>St. Leonard, Md.</b>   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>St. Leonard</b>   |                                  |   |   | DATE SIGNED<br><b>9/23/58</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>9-24-58</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Harmony</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Mt Dwiggs Md</b>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hutchins Funeral Home, Dwiggs Md</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 25 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>William D. Thomas</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2064162XVI

# CERTIFICATE OF DEATH

10012

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

|                        |  |              |  |               |  |               |  |                 |  |
|------------------------|--|--------------|--|---------------|--|---------------|--|-----------------|--|
| NAME OF DECEASED       |  | SEX          |  | AGE           |  | DATE OF BIRTH |  | PLACE OF BIRTH  |  |
| JAMES EARL RAY         |  | MALE         |  | 35            |  | JAN 5, 1928   |  | MOBILE, ALABAMA |  |
| MARRIAGE               |  | DATE         |  | PLACE         |  | DATE          |  | PLACE           |  |
| MARRIED                |  | JAN 15, 1950 |  | BALTIMORE, MD |  | JAN 15, 1950  |  | BALTIMORE, MD   |  |
| OCCUPATION             |  | DATE         |  | PLACE         |  | DATE          |  | PLACE           |  |
| CONTRACTOR             |  | JAN 15, 1950 |  | BALTIMORE, MD |  | JAN 15, 1950  |  | BALTIMORE, MD   |  |
| CAUSE OF DEATH         |  | DATE         |  | PLACE         |  | DATE          |  | PLACE           |  |
| HEART DISEASE          |  | JAN 15, 1950 |  | BALTIMORE, MD |  | JAN 15, 1950  |  | BALTIMORE, MD   |  |
| MANNER OF DEATH        |  | DATE         |  | PLACE         |  | DATE          |  | PLACE           |  |
| NATURAL                |  | JAN 15, 1950 |  | BALTIMORE, MD |  | JAN 15, 1950  |  | BALTIMORE, MD   |  |
| SIGNATURE OF PHYSICIAN |  | DATE         |  | PLACE         |  | DATE          |  | PLACE           |  |
| JAMES EARL RAY         |  | JAN 15, 1950 |  | BALTIMORE, MD |  | JAN 15, 1950  |  | BALTIMORE, MD   |  |
| SIGNATURE OF REGISTRAR |  | DATE         |  | PLACE         |  | DATE          |  | PLACE           |  |
| JAMES EARL RAY         |  | JAN 15, 1950 |  | BALTIMORE, MD |  | JAN 15, 1950  |  | BALTIMORE, MD   |  |

10757

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |  |  |
|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert Co.</b> <b>MARYLAND</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Calvert Co.</b>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>   |   | c. LENGTH OF STAY IN 1b <b>1-Yr. 5 Months</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Calvert Nursing Home</b>  |   | e. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print) <b>ARTHUR D. MOFFETT</b>   |   | 4. DATE OF DEATH <b>Sept 8, 1958</b>   |  |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Jan 25-1873</b>                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Met. Police Dept.</b>   | 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>                |
| 13. FATHER'S NAME <b>Henry Moffett</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Viola Russ</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)  |   | 17. INFORMANT <b>Paul Moffett</b> Address <b>Same as # 2.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO <b>331X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b><br>DUE TO <b>ca 2 rigidoid (3?)</b><br>(c) <b>ca 2 rigidoid (3?)</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                     |
| 21. I certify that I attended the deceased from <b>Sept 5, 1958</b> to <b>Sept 8, 1958</b> that I last saw the deceased alive on <b>Sept 8, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.   |   |  |  |
| ACTUAL SIGNATURE <b>Roberto de Villarreal</b> M.D.   |   | ADDRESS (Street, city or town, state) <b>S. Hemond, N.</b> DATE SIGNED <b>9/8/58</b>   |  |
| PHYSICIAN'S NAME (Type) <b>ROBERTO de VILLARREAL</b>   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>Sept 11-58</b>   | 22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  | 22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Sammons Bros.</b> ADDRESS <b>1661- Good Hope Road SE.</b>  |   | 24a. REC'D BY REGISTRAR <b>DATE SEP 10 58</b>  | 24b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

10016

10009

Reg. Dist. No. ....

|  |                                      |   |   |  |                                       |  |                                       |
|--|--------------------------------------|---|---|--|---------------------------------------|--|---------------------------------------|
| <b>1. PLACE OF DEATH</b>   |                                      |   |   | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |                                       |  |                                       |
| COUNTY <u>Calvert</u>  |                                      | MARYLAND  |   | STATE <u>Md.</u>   |                                       | COUNTY <u>Charles</u>  |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Prince Frederick</u>  |                                      | LENGTH OF STAY (in this place)<br><u>1 1/2 months</u>   |   | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>Waldorf</u> |                                       | <u>08X-2</u>   |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>Calvert Nursing Home</u>   |                                      |   |   | STREET ADDRESS (If rural give location)  |                                       |  |                                       |
| <b>3. NAME OF DECEASED</b> (First) (Middle) (Last)<br><u>Charles William Pickeral</u>  |                                      |   |   | <b>4. DATE OF DEATH</b> (Month) (Day) (Year)<br><u>Sept. 14, 1958</u>                        |                                       |  |                                       |
| <b>5. SEX</b><br><u>m</u>  | <b>6. COLOR OR RACE</b><br><u>W.</u> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><u>Widowed</u>                                     | <b>8. DATE OF BIRTH</b><br><u>Oct 6, 1876</u> | <b>9. AGE last birthday</b><br><u>79</u> yrs.  | <b>IF UNDER 1 YEAR</b><br>Months Days |  | <b>IF UNDER 24 HRS.</b><br>Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>  |                                      | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Farming</u>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Maryland</u>                          |                                       | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>                   |                                       |
| <b>13. FATHER'S NAME</b><br><u>DOC Pickeral</u>  |                                      |   |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Julie Ann ?</u>  |                                       |  |                                       |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)<br><u>NO</u>  |                                      | <b>16. SOCIAL SECURITY NO.</b><br><u>NONE</u>   |   | <b>17. INFORMANT &amp; ADDRESS</b><br><u>George C. Atkinson, Waldorf, Md.</u>                |                                       |  |                                       |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>  |                                      |   |   | <b>18. MEDICAL CERTIFICATION</b>   |                                       |  |                                       |
| <b>422.1 IMMEDIATE CAUSE</b> (A) <u>Cardio vascular disease</u>  |                                      |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>10 yrs</u>                                     |                                       |  |                                       |
| <b>ANTECEDENT CAUSE(S)</b> DUE TO  |                                      |   |   |  |                                       |  |                                       |
| <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO   |                                      |   |   |  |                                       |  |                                       |
| <b>STATING UNDERLYING CAUSE LAST.</b> DUE TO   |                                      |   |   |  |                                       |  |                                       |
| <b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                                      |   |   |  |                                       |  |                                       |
| <b>19a. DATE OF OPERATION</b>  |                                      | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |   | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |  |                                       |
| <b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>  |                                      | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |   | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                          |                                       |  |                                       |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)  |                                      | <b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>21f. HOW DID INJURY OCCUR?</b>  |                                       |  |                                       |
| <b>22. I hereby certify that I attended the deceased from Jan 13, 1958, to Sept 14, 1958, that I last saw the deceased alive on Jan 13, 1958, and that death occurred at 5:20 P.M. from the causes and on the date stated above.</b> |                                      |   |   |  |                                       |  |                                       |
| <b>SIGNATURE</b><br><u>H W Ward</u>  |                                      |   |   | <b>DATE SIGNED</b><br><u>Overing Md 9/14/58</u>  |                                       |  |                                       |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><u>Burial</u>   |                                      | <b>DATE THEREOF</b><br><u>9/17/58</u>   |   | <b>NAME OF CEMETERY OR CREMATORY</b><br><u>Oakland Cem.</u>                                  |                                       | <b>LOCATION (City, town, or county) (State)</b><br><u>Waldorf, Md.</u> |                                       |
| <b>24. REC'D BY REGISTRAR</b><br>DATE <u>SEP 17 '58</u>  |                                      | <b>REGISTRAR'S SIGNATURE</b><br><u>Arthur J. Hume</u>   |   | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>The Hunt &amp; Funeral Home, Waldorf, Md.</u>  |                                       |  |                                       |



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the Registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10017 CERTIFICATE OF DEATH

10010

Reg. Dist. No. ....

|   |                                  |  |  |  |  |   |   |
|---|----------------------------------|--|--|--|--|---|---|
| <b>1. PLACE OF DEATH</b>  |                                  |  |  | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>   |  |   |   |
| COUNTY <i>Calvert</i>   |                                  | MARYLAND   |  | STATE <i>md.</i>   |  | COUNTY <i>Calvert</i>   |   |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <i>Prince Frederick</i>   |                                  | LENGTH OF STAY (in this place)<br><i>6 mos.</i>  |  | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <i>Solomons</i> |  |   |   |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><i>Calvert Nursing Home</i>  |                                  |  |  | STREET ADDRESS (If rural give location)<br><i>1</i>  |  |   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or Print)<br>(First) (Middle) (Last)<br><i>James Albert Robinson</i>  |                                  |  |  | <b>4. DATE OF DEATH</b><br>(Month) (Day) (Year)<br><i>Sept. 16 1958</i>                          |  |   |   |
| 5. SEX<br><i>Male</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><i>Single</i>                                      | 8. DATE OF BIRTH<br><i>May 24 1888</i> | 9. AGE last birthday<br><i>70</i> yrs.   | IF UNDER 1 YEAR<br>Months Days                                       |   | IF UNDER 24 HRS.<br>Hours Min.              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Waterman</i>  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY      |  | 11. BIRTHPLACE (State or foreign country)<br><i>Brownsville, Md.</i> |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i> |
| 13. FATHER'S NAME<br><i>James Oliver Robinson</i>   |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><i>Susan Stafford</i>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)   |                                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT & ADDRESS<br><i>Minnie Robinson Solomons, Md.</i>                                  |  |   |   |
| <b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                                  |  |  | <b>18. MEDICAL CERTIFICATION</b>   |  |   |   |
| 442X IMMEDIATE CAUSE (A) <i>Cardio Vascular Renal Disease</i>   |                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 yrs</i>   |  |   |   |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Age</i>   |                                  |  |  |  |  |   |   |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Rain in Chest</i>   |                                  |  |  |  |  |   |   |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>   |                                  |  |  |  |  |   |   |
| 19a. DATE OF OPERATION  |                                  | 19b. MAJOR FINDINGS OF OPERATION   |  |  |  |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)                                     |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)   |                                  | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?   |  |   |   |
| 22. I hereby certify that I attended the deceased from <i>4/11</i> 19 <i>58</i> , to <i>9/16</i> 19 <i>58</i> , that I last saw the deceased alive on <i>9/14</i> 19 <i>58</i> , and that death occurred at <i>6:45</i> M., from the causes and on the date stated above. |                                  |  |  |  |  |   |   |
| SIGNATURE<br><i>H. W. Ward</i>  |                                  |  |  | ADDRESS (Street, city, town, state)<br><i>Owings, Md.</i>  |  |   |   |
| DATE<br><i>SEP 19 58</i>  |                                  |  |  | DATE SIGNED<br><i>9/16/58</i>  |  |   |   |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |                                  | DATE THEREOF<br><i>Sept</i>  |  | NAME OF CEMETERY OR CREMATORY<br><i>Solomons Methodist</i>                                       |  | LOCATION (City, town, or county) (State)<br><i>Solomons, Md.</i>      |   |
| 24. REC'D BY REGISTRAR<br><i>SEP 19 58</i>  |                                  | REGISTRAR'S SIGNATURE<br><i>Arthur L. Frank</i>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><i>W. Harkness &amp; Son</i>                                 |  | ADDRESS<br><i>Mt. Airy, Md.</i>                                       |   |

# CERTIFICATE OF DEATH

10012

REG. DIST. NO.

1. NAME OF DECEASED (Print or Write)

MARYLAND

1. SEX

2. AGE

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CLERGY

15. SIGNATURE OF OTHER

16. SIGNATURE OF

17. SIGNATURE OF

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ENCLOSURE

1. NAME OF DECEASED (Print or Write)  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. PLACE OF DEATH  
10. TIME OF DEATH  
11. SIGNATURE OF PHYSICIAN  
12. SIGNATURE OF REGISTRAR  
13. SIGNATURE OF WITNESSES  
14. SIGNATURE OF FUNERAL HOME  
15. SIGNATURE OF CLERGY  
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CERTIFICATE OF DEATH

10011

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 wks.</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Calvert County Hospital</b>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Broomes Island</b>   |  |  |  |
|  |  |   |  | f. STREET ADDRESS<br><b>1</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Ida Sewell</b> Middle Last   |  |   |  | 4. DATE OF DEATH<br>Month <b>Sept.</b> Day <b>13</b> Year <b>1958</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug. 6, 1875</b>  |  |
| 9. AGE (In years lost birthday)<br><b>83</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>John Elliott</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Orem</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  | 17. INFORMANT<br>Address<br><b>Clarence Sewell, Broomes Island, Md.</b>              |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Central thrombosis - hemolysis</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b><br>(c) <b>Generalized arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)               |  |
|  |  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>May</b> , 19 <b>58</b> , to <b>Sept 12</b> , 19 <b>58</b> , that I lost saw the deceased alive on <b>Sept 12</b> , 19 <b>58</b> , and that death occurred at <b>1</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>Sept 13/58</b>   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Roberto de Villarreal</b> M.D.  |  |   |  | PHYSICIAN'S NAME (Type)<br><b>ROBERTO DE VILLARREAL</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Sept 15, 1958</b> |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Broomes Island Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Broomes Island, Calvert, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>G. A. Harkness &amp; Son, Mutual, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 17 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| <p>1. Name of Deceased: <u>John Doe</u></p>           |  | <p>2. Sex: <u>Male</u></p>                                   |  |
| <p>3. Date of Birth: <u>Jan 1, 1900</u></p>           |  | <p>4. Age: <u>22</u> years</p>                               |  |
| <p>5. Place of Birth: <u>New York City</u></p>        |  | <p>6. Usual Residence: <u>123 Main St, Baltimore, Md</u></p> |  |
| <p>7. Date of Death: <u>Jan 15, 1922</u></p>          |  | <p>8. Time of Death: <u>10:00 AM</u></p>                     |  |
| <p>9. Cause of Death: <u>Heart Disease</u></p>        |  | <p>10. Manner of Death: <u>Natural</u></p>                   |  |
| <p>11. Signature of Physician: <u>[Signature]</u></p> |  | <p>12. Signature of Registrar: <u>[Signature]</u></p>        |  |
| <p>13. Date of Registration: <u>Jan 16, 1922</u></p>  |  | <p>14. Place of Registration: <u>Baltimore, Md</u></p>       |  |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10012

10019

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Prince Frederick</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>X</b> <b>Lower Marlboro</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Calvert Nursing Home</b>  |                                     | d. STREET ADDRESS<br><b>1</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ELLIOTT</b> Middle <b>HERBERT</b> Last <b>SHECKELLS</b>  |                                     | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>17</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 31, 1878</b>                                    |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.  |                                     | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   | IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farming</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farm Owner</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>Maryland</b>   |  |
| 13. FATHER'S NAME<br><b>Elliott Sheckells</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Mary Gibson</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                     | 16. SOCIAL SECURITY NO.<br><b>216-12-4954</b>   |  |
| 17. INFORMANT<br><b>Mrs. Ruth Grover</b>   |                                     | Address<br><b>Owings, Maryland</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio Vascular Renal Decm</b><br><b>442X</b> DUE TO <b>Age</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Age</b><br>DUE TO (c) <b>Age</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 yrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>19</b>  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>21</b> <b>1958</b> , to <b>Sept 19</b> <b>1958</b> , that I last saw the deceased alive on <b>9/16</b> <b>1958</b> , and that death occurred at <b>11:22 PM</b> , from the causes and on the date stated above.   |                                     | ADDRESS (Street, city or town, state) <b>Owings Md</b> DATE SIGNED <b>9/18/58</b>   |  |
| ACTUAL SIGNATURE <b>H W Ward</b> M.D. <b>Owings Md</b>   |                                     |   |  |
| PHYSICIAN'S NAME (Type) <b>H. W. Ward</b> <b>Owings, Maryland</b>  |                                     |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>9-20-58</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>All Saints</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Sunderland Md</b>          |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Eulachin Funeral Home, Owings Md</b>  |                                     | 24a. REC'D BY REGISTRAR<br><b>SEP 23 '58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. House</b>   |                                     |   |  |

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10013

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Calvert</i><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bassett</i><br>c. LENGTH OF STAY IN 1b   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <i>Md</i><br>b. COUNTY <i>Calvert</i><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Bassett</i>  |  |
| 3. NAME OF DECEASED (Type or print) <i>Wm</i> First <i>Stallings</i> Middle <i>Stallings</i> Last<br>4. DATE OF DEATH <i>9</i> Month <i>27</i> Day <i>1958</i> Year   |  | 5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>5/19/39</i> 9. AGE (in years last birthday) <i>19</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i> 11. BIRTHPLACE (State or foreign country) <i>Md</i> 12. CITIZEN OF WHAT COUNTRY?   |  | 13. FATHER'S NAME <i>Victor Stallings</i> 14. MOTHER'S MAIDEN NAME <i>Egnes Cochran</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. 17. INFORMANT <i>Victor Stallings, Prince Frederick</i> Address   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Fractured skull and neck</i><br>816X DUE TO (b) <i>Sustained in Auto Accident</i><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Was passenger in a car collision</i>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Auto accident Calvert Md</i>   |  |
| 20c. TIME OF INJURY Month, Day, Year <i>4:30</i> Hour <i>9/27</i> 19 <i>58</i> p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway 2 Prince Frederick Calvert Md</i> 20f. City or town (County) (State) |  | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |
| ACTUAL SIGNATURE <i>H W Ward</i> EXAMINER'S NAME (Type) <i>H. W. Ward, Owings, Maryland</i>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Owings Md</i>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>9-30-58</i> 22c. NAME OF CEMETERY OR CREMATORY <i>St Pauls</i> 22d. LOCATION (City, town, or county) (State) <i>Prince Frederick Md</i>  |  | 23. FUNERAL DIRECTOR'S SIGNATURE <i>Hulthaus Funeral Home, Owings Md.</i> ADDRESS <i>2nd</i> 24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i> DATE <i>OCT 1 '58</i> 24b. REGISTRAR'S SIGNATURE  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, stating the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

10014

Reg. Dist. No.

10021

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Calvert</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dunkirk</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>5 years</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |  |  |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dunkirk</b>  |  |  |  |
| d. STREET ADDRESS   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) First <b>GEORGE</b> Middle <b>LEONARD</b> Last <b>WALTON</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>22</b> Year <b>1958</b>   |  |  |  |
| 5. SEX<br><b>male</b>   |  | 6. COLOR OR RACE<br><b>White</b>                                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 23, 1885</b>                                    |  |
| 9. AGE (In years last birthday)<br><b>73</b>  |  | IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min. |  | IF UNDER 24 HRS.<br>Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farming</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Tenant</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>Maryland</b>   |  |  |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Charles Walton</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service) <b>—</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>217-36-7956</b>   |  | 17. INFORMANT<br><b>Mrs. Leonard Walton, Dunkirk, Maryland</b>               |  |
| 18. CAUSE OF DEATH [Enter only one cause primary for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of duodenum Colon</b><br><b>153.2</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Diarrhea</b><br>DUE TO<br>(c) <b>—</b> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b><br><b>2 mos</b>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <b>19</b><br>p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town)<br><b>Nr. Owings, Maryland</b>  |  |  |  | 20g. (County)<br><b>Nr. Owings, Maryland</b>  |  |  |  |
| 20h. (State)<br><b>Nr. Owings, Maryland</b>   |  |  |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>Jan 1958</b> to <b>Sept 22, 1958</b> , that I last saw the deceased alive on <b>Sept 16, 1958</b> and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>H. W. Ward</b>   |  |  |  | DATE SIGNED<br><b>9/24/58</b>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>H. W. Ward</b>  |  |  |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Sept. 24 - 58</b>                              |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Harmony</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Nr. Owings, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Hutchins Funeral Home Owings</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>SEP 25 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles S. Knead</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

10082

PLACE OF DEATH

MARRIAGE

DATE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

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